STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125020	A. BUILDING: _____ B. WING _____	08/12/2019

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AVALON CARE CENTER - HONOLULU, LLC	1930 KAMEHAMEHA IV RD HONOLULU, HI 96819

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4 000	Initial Comments A relicensure survey was conducted from 08/06/19 to 08/12/19. At the entrance conference there were 94 residents reported on the census.	4 000		
4 101	11-94.1-22(c) Medical record system (c) The following information shall be obtained and entered in the resident's record at the time of admission to the facility: (1) Personal information such as name, date, and time of admission, date and place of birth, citizenship status, marital status, social security number, or an admission number that can be used to identify the resident without use of name when the latter is desirable; (2) Name and address of next of kin, legal guardian, surrogate, or representative holding a power of attorney; (3) Sex, height, weight, race, and identifying marks; (4) Reason for admission or referral; (5) Language spoken and understood; (6) Information relevant to religious affiliation, if any; (7) Admission diagnosis, summary of prior medical care with listing of physicians providing care, recent physical examination, tuberculosis status, and physician's orders; and (8) Advanced directives, as applicable.	4 101		9/9/19

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4 101	Continued From page 1 This Statute is not met as evidenced by: Based on record review, interview with staff members and a review of the facility's policy and procedure, the facility failed to ensure residents were provided with the right to formulate an advance directive (including whether the residents requested assistance in formulating an advance directive) and the facility failed to ensure residents were periodically offered the opportunity to formulate an advance directive for 4 (Residents 148, 41, 3 and 96) of 24 residents reviewed. Findings include: 1) On the morning of 08/07/19 a record review for Resident (R)148 found the resident was admitted to the facility on 07/30/19. Further review of the electronic medical record (EMR) could not find documentation of an advance directive or Physician Order for Life-Sustaining Treatment (POLST). An interview was conducted with Social Worker (SW)1. The SW was agreeable to review the resident's EMR and chart for information related to an advance directive On 08/07/19 at 09:07 AM, the SW provided a progress note dated 08/07/19 to document R148's family was contacted and confirmed R148 does not have an advance directive. SW1 scheduled a meeting with the family for 08/08/19. Subsequently, at 09:55 AM, the SW provided a copy of the POLST which was signed on 08/07/19 by the physician. 2) On the morning of 08/07/19 a record review was done for R41. R41 was admitted to the facility on 06/30/18, there was no documentation of an advance directive. An interview was done with the SW, the SW was agreeable to review the	4 101	1.Resident 148, 41, 3, and 96 medical records were reviewed to ensure they had been provided with education regarding their right to formulate an Advanced Health Care Directive. 2.Residents residing in the facility have the potential to be affected. 3.Administrator educated Social Services staff on facility policy regarding documentation of patient and/or POA education regarding the right to formulate an AHCD directive. 4.Social Services will conduct audits to validate residents and/or POA are being provided with education regarding their right to formulate an AHCD weekly x 4 weeks, then per week x 2 months to validate that current policy and procedure are being followed. Social Services will report findings to the QAPI committee to evaluate the effectiveness of the plan based on the finding and implement additional intervention to ensure continuous compliance. Compliance will be achieved by 9/9/19.	

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4 101	Continued From page 2 resident's chart. On 08/07/19 at 09:07 AM, the SW provided a progress note dated 09/07/18 documenting the resident and the responsible party was notified of the right to formulate an advance directive and given a copy of the policy. The documentation did not indicate whether the resident and/or the responsible party requested aid to formulate an advance directive. The SW was asked whether the facility periodically reviews advance directive information for those residents without a directive. Further queried whether the facility has documentation whether the resident or the responsible party declined or requested assistance to formulate an advance directive. The SW reported the facility will review advance directives quarterly and annually. A request was made for documentation of the facility's periodic discussion with the resident or responsible party regarding advance directives. The facility was unable to provide documentation of whether the resident and/or the responsible party declined the option to formulate an advance directive. Also, there was no subsequent documentation of periodic review regarding the right to formulate an advance directive. 3) On the morning of 08/07/19 a record review was done for R3. This resident was admitted on 08/01/18. The review found there was no documentation of an advance directive. An interview was conducted with the SW. The SW was agreeable to review R3's records for an advance directive. On 08/07/19 at 09:07 AM, the SW provided documentation which was dated 09/07/18 that notes the resident and the	4 101		

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4 101	Continued From page 3	4 101		

responsible party were notified of the right to an advance directive and provided a copy of the facility's policy. There was no documentation of whether the resident or the responsible party declined the assistance to formulate a directive. The SW confirmed the documentation does not include whether the resident or the responsible party was interested in formulating a directive. A request was made to review documentation of periodic discussion regarding formulation of an advance directive.

On 08/08/19 at 2:01 PM, SW1 provided a copy of the "IDT Care Plan Conference" dated 02/06/19 documenting advance directive was reviewed and discussed with resident's spouse. The documentation notes the SW discussed advance directives and POLST, as well as, offered assistance in creating a POLST or advance health care directive. There was no documentation whether the spouse wanted assistance with either.

Following the discovery of the deficient practice, R3 had an IDT care plan conference on 08/08/19 at 10:09 AM which documents R3's current POLST is on file and the resident's spouse was offered assistance in updating/creating POLST and advance health care directive. The spouse refused assistance at this time.

4) On the morning of 08/07/19 a record review was done for R96. R96 was admitted on 07/25/19. The review of the EMR found no documentation of an advance directive. An interview was done with SW1, the SW was agreeable to follow up. At 09:07 AM the SW provided a copy of the IDT Care Plan Conference/Welcome Meeting form (dated 08/07/19). The team documented on the form,

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4 101	Continued From page 4 the POLST and advance directive education was given at this time. The SW confirmed there is no acknowledgement of whether the resident requested assistance in formulating an advance directive. On 08/07/19 at 09:07 AM, SW1 provided the facility's policy and procedures for advance directive. The guidelines include the following: "1. Upon admission, staff will verify the formulating of an advance directive or the resident's wishes with regards to formulating an advance directive. Resident's wishes may be communicated through the resident representative"; and "3. Upon admission, if the resident has not formulated an advance directive, the facility will determine if the resident wishes to formulate an advance directive. As indicated, the facility will inform the resident of his or her right to establish advance directives and will aid the resident in the development of advance directives in accordance with state law. The resident can accept or decline the help. Documentation in the medical record will reflect the discussion of advance directive occurred, and that assistance has been offered to the resident, and the resident's acceptance or declination of assistance".	4 101		
4 105	11-94.1-22(g) Medical record system (g) All entries in a resident's record shall be: (1) Accurate and complete; (2) Legible and typed or written in black or blue ink; (3) Dated;	4 105		9/9/19

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4 105	Continued From page 5 (4) Authenticated by signature and title of the individual making the entry; and (5) Written completely without the use of abbreviations except for those abbreviations approved by a medical consultant or the medical doctor. This Statute is not met as evidenced by: Based on record review, staff interview, and review of the Accepted Abbreviations List (provided by the facility), the facility failed to use approved abbreviations when charting in the progress notes, for four out of the eight residents reviewed. With this deficient practice, there was a risk of misinterpreting the un-approved abbreviations and thus causing adverse outcomes for any, or all the residents. Findings Include: 1. During review of the progress notes for Resident (R) 47, the following abbreviations were used, in various places, in the progress notes: "RP, TAR". According to the Accepted Abbreviations List (provided by the facility), these abbreviations were not approved to be used for charting. 2. During review of the progress notes for Resident (R) 14, the following abbreviation was used, in various places, in the progress notes: "RP". According to the Accepted Abbreviations List (provided by the facility), this abbreviation was not approved to be used for charting. 3. During review of the progress notes for	4 105	Residents residing in the facility have the potential to be affected. DON re-educated licensed staff on 8/9/19, 8/13 and 8/14 on the approved Abbreviations policy. DON or designee will conduct audits of 4 resident's charts x4 weeks, then 4 residents per week x 2 months to validate that licensed staff are following current policy and procedure for using approved abbreviations. DON will report findings to QAPI committee to evaluate the effectiveness of the plan based on findings and implement additional intervention to ensure continuous compliance. Compliance will be achieved by 9/9/19.	

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4 105	Continued From page 6 Resident (R) 9, the following abbreviation was used, in various places, in the progress notes: "LS". According to the Accepted Abbreviations List (provided by the facility), this abbreviation was not approved to be used for charting. 4. During review of the progress notes for Resident (R) 84, the following abbreviation was used, in various places, in the progress notes: "RP". According to the Accepted Abbreviations List (provided by the facility), this abbreviation was not approved to be used for charting. On 08/09/19 at 09:25 PM, inquiry with the Director of Nursing (DON) was done. DON acknowledged that the abbreviations, previously mentioned, were not approved to be used for charting.	4 105		
4 113	11-94.1-27(2) Resident rights and facility practices Written policies regarding the rights and responsibilities of residents during the resident's stay in the facility shall be established and shall be made available to the resident, resident family, legal guardian, surrogate, sponsoring agency or representative payee, and the public upon request. A facility must protect and promote the rights of each resident, including: (2) The right to be free of interference, coercion, discrimination, and reprisal from the facility that shall include the right to be free of chemical or physical restraints not medically indicated; This Statute is not met as evidenced by:	4 113		9/9/19

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4 113	Continued From page 7 Based on an anonymous resident interview, the facility failed to ensure a resident has the right to voice grievances to the facility or other agency or entity without discrimination or reprisal and without fear of discrimination or reprisal. Findings include: On 08/17/19 at 08:06 AM an anonymous interview was conducted by request of the resident. The resident reportedly had many concerns regarding the facility; however, recognizes the "walls get ears" so has not voiced concerns. The resident reported being concerned that staff members may retaliate by being slow to respond to the call light. The resident reported a hair in her/his food then later the kitchen would send hot water without the tea bag and on another occasion sent a tea bag but no hot water.	4 113	1.No resident was identified since it was an anonymous interview. Administrator and DON re-educated staff on Grievance process. 2. Residents residing in the facility have the potential to be affected. 3. Recreation Director or designee will provide education to members of the resident council on the Grievance process on 9/9/19. 4. Recreation Director or designee will conduct audits of 5 resident's x4 weeks, then 5 residents per week x2 months to validate that residents understand the grievance process and current policy and procedure are being followed by staff. Activities Director will report findings to QAPI committee to evaluate the effectiveness of the plan based on findings and implement additional intervention to ensure continuous compliance. Compliance achieved by 9/9/19.	
4 115	11-94.1-27(4) Resident rights and facility practices	4 115		9/9/19

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4 115	Continued From page 8 Written policies regarding the rights and responsibilities of residents during the resident's stay in the facility shall be established and shall be made available to the resident, resident family, legal guardian, surrogate, sponsoring agency or representative payee, and the public upon request. A facility must protect and promote the rights of each resident, including: (4) The right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility; This Statute is not met as evidenced by: Based on resident interviews, the facility failed to treat each resident with respect and dignity and provide care to residents in an environment that promotes maintenance of enhancement of his or her quality of life. Findings include: 1) On 08/06/19 at 10:48 AM a confidential resident interview was conducted. The resident reported that staff members are speaking in a non-dominant language of the facility in the resident's room. The resident stated he/she is not sure whether staff members are talking about him/her or making faces at him/her. On 08/07/19 an interview was done with resident council representatives. The representatives were asked whether staff members are speaking in the non-dominant language of the facility. The representatives confirmed staff members are heard speaking to one another in another language and this occurs especially when there	4 115	No resident was identified since it was an anonymous interview. All residents residing in the facility have the potential to be affected. Administrator and DON re-educated staff on answering call lights in a timely manner and speaking in the facility's dominant language when providing care or communicating with residents unless it is the resident's preference to speak in their native language on 8/13/19 and at All Staff on 9/13. Administrator or designee will conduct audit on 4 residents weekly for 4 weeks, then 4 residents per week x 2 months, to	

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4 115	Continued From page 9 are two staff members present. One representative reported this occurs on a daily. 2) On 08/17/19 at 08:06 AM a confidential resident interview was conducted. The resident reported during lunch, she/he has had to wait for assistance to change personal brief. The resident recalled the longest amount of time she/he had to wait was one hour. The resident also reported the facility does not have enough staff members to provide care, especially during meal times and overall states the staff members here are overworked and underpaid. 3) On 08/07/19 an interview was done with the resident council representatives. On resident reported pressing the call light and having to wait a long time for assistance. Eventually the resident will use her/his cellular phone to call the facility to get assistance. Other representatives reported the call light is activated and the staff members respond to inquire what kind of assistance is required, then the staff member will tell the resident that they will come back as they are involved with another resident. 4) On 08/06/19 at 9:00 AM a confidential resident interview was conducted. The resident reported waiting approximately a half hour at night before the staff member provides care. The resident clarified the call light is being pressed to request medication.	4 115	validate that staff are following current policy and procedures for using facility's dominant language and answering call lights in a timely manner. Administrator will report findings to QAPI committee meeting to evaluate the effectiveness of the plan based on findings and implement additional intervention to ensure continuous compliance.	
4 159	11-94.1-41(a) Storage and handling of food (a) All food shall be procured, stored, prepared, distributed, and served under sanitary conditions.	4 159		9/9/19

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4 159	Continued From page 10 (1) Dry or staple food items shall be stored above the floor in a ventilated room not subject to seepage or wastewater backflow, or contamination by condensation, leakages, rodents, or vermin; and (2) Perishable foods shall be stored at the proper temperatures to conserve nutritive value and prevent spoilage. This Statute is not met as evidenced by: Based on observation and interview with staff member, the facility failed to prepare food under sanitary conditions. Findings include: On 08/08/19 at 08:50 AM a follow up to the kitchen was done to observe food preparation. The Nutrition Services Director (NSD) was present during the observation. The concurrent observation found a colander filled with raw chicken placed in the sink. The Nutrition Services Cook (NSC)1 was observed to prepare an herb mixture for the chicken. The cook donned gloves and removed three pieces of chicken and placed it on a small metal bowl and placed on a rolling cart. The cook explained these pieces will be used for the no added salt diets. The rest of the raw chicken was placed on baking trays. The cook removed gloves, washed his/her hands, tied the apron, donned gloves, then proceeded to sprinkle the herb mixture onto the chicken. After placing all the chicken on the baking tray, NSC1 removed the colander from the sink and carried it across the kitchen to the three-compartment sink to be washed. While traveling across the kitchen, the cook placed one	4 159	1. Residents residing in the facility have the potential to be affected. 2. The raw chicken in the metal bowl was immediately discarded. The Nutrition Services Cook was re-educated on 8/8/19 regarding proper handling of raw meat. 3.Dietary Supervisor provided education to dietary staff regarding policy and procedures for handling raw meat on 8/13/19. 4. Dietary Supervisor will audit 3x/week for 4 weeks, then weekly x2 months to validate that dietary staff are compliance with handling raw meat. Dietary Supervisor will report findings to QAPI committee to evaluate the effectiveness of the plan based on findings and implement additional intervention to ensure	

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4 159	Continued From page 11 hand under the colander to catch the drips; however, some of the pink-tinged liquid dripped to the floor. The NSD was asked about the liquid that dripped to the floor, the NSD then asked a staff member to mop up the drippings. At 09:05 AM, upon return to the cooking area, the three pieces of raw chicken in the metal bowl remained on the cart which was placed in front of the steamer. NSC1 was observed to rinse the sink with water, removed the drain strainer and empty the contents into the rubbish can next to the sink. NSC1 was observed to get a pitcher and fill it with water at the sink. The NSD was asked whether the sink requires sanitation or is rinsing the sink with water enough to clean the sink after the colander of raw chicken was being strained in the sink. The NSD acknowledged the sink needed to be sanitized and directed the staff member to sanitize the sink with quat solution. At 09:20 AM, approximately a half hour later, the three pieces of raw chicken were still stored in the metal bowl on the cart. The NSD was asked about the chicken, the NSD responded the cook probably forgot about it but it should be okay as there is still ice from the chicken. The cook began to apply plastic wrap to cover the raw chicken. A request was made to check the temperature of the raw chicken. The temperature was 46 degrees Fahrenheit. Further inquired whether this was the appropriate holding temperature for raw chicken and okay to prepare for lunch. The NSD responded the holding temperature of raw chicken should be below 40 degrees Fahrenheit. The NSD instructed the cook to throw the raw chicken.	4 159	continuous compliance. Compliance will be achieved by 9/9/19.	

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4 160	Continued From page 12	4 160		
4 160	11-94.1-41(b) Storage and handling of food (b) Effective procedures to promptly and consistently clean all equipment and work areas shall be enforced. This Statute is not met as evidenced by: Based on observation and interview with staff member, the facility failed to clean dishes under sanitary conditions. Findings include: On 08/08/19 at 11:30 AM observation was made of the dish wash machine. The plastic dish crates which house the dirty dishes (plates, cups) as it goes through the washing process was observed to have white and brown substance on the exterior and in the crevices of the slots. The NSD reported the white substance is hard water build up and proceeded to scrape the brown substance off the surface of the crates with his/her fingernail. Inquired when was the last time the dish crates were cleaned, the NSD responded the crates are cleaned once a week. There were over 34 crates that were covered with brown and white substance. One crate had a greenish/blackish material hanging from the side of the crate (possibly dried up vegetable).	4 160	1. Residents residing in the facility have the potential to be affected. 2. The raw chicken in the metal bowl was immediately discarded. The Nutrition Services Cook was re-educated on 8/8/19 regarding proper handling of raw meat. 3. Dietary Supervisor provided education to dietary staff regarding policy and procedures for handling raw meat on 8/13/19. 4. Dietary Supervisor will audit 3x/week for 4 weeks, then weekly x2 months to validate that dietary staff are compliance with handling raw meat. Dietary Supervisor will report findings to QAPI committee to evaluate the effectiveness of the plan based on findings and implement additional intervention to ensure continuous compliance.	9/9/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125020	A. BUILDING: _____ B. WING _____	08/12/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVALON CARE CENTER - HONOLULU, LLC	1930 KAMEHAMEHA IV RD HONOLULU, HI 96819

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4 160	Continued From page 13	4 160	Compliance will be achieved by 9/9/19.	
4 221	11-94.1-56(a) Laundry service (a) Laundry service shall be managed so that daily clothing and linen needs are met without delay and in compliance with facility policies and procedures for infection control. This Statute is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain a clean and sanitary environment in the "Laundry Shoot". This deficient practice put all the residents at risk for the potential development and transmission of communicable diseases and infections. Findings Include: During an observation of the "Laundry Shoot" on 08/09/19 at 09:30 AM, the lower part of the shoot was noted to have a dark black/brown "spotted" coating. The Maintenance Director (Maint Dir) and the Environmental Services Dir (ES Dir), who accompanied the above observation, were queried about the dark black/brown "spotted" coating, but did not know what the coating was. Thus, the Maint Dir and ES Dir both stated that there was no current procedure/process for cleaning the "Laundry Shoot" and/or maintaining a sanitary environment in that "Laundry Shoot".	4 221	1. There are no residents being affected. 2. Laundry Shoot was cleaned on 8/9/19. Maintenance staff will clean the laundry shoot weekly and will be noted in the laundry shoot cleaning log. 3. Environmental Services Director provided education to Maintenance staff on 8/9/19 to include weekly cleaning of the laundry shoot. 4. Environmental Services Director will conduct audits of laundry shoot cleaning and log x 4 weeks, then weekly x 2 months to validate that laundry shoot is being cleaned and log is being kept. Environmental Services Director will report findings to the QAPI committee to evaluate the effectiveness of the plan based on finding and implement additional	9/9/19

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4 221	Continued From page 14	4 221	intervention to ensure continuous compliance. Compliance will be achieved by 9/9/19	
4 243	11-94.1-64(a) Engineering and maintenance (a) The facility shall maintain all essential mechanical, electrical, and resident care equipment in safe operating condition. This Statute is not met as evidenced by: Based on observations, and staff interview, the facility failed to identify potential electrical accident hazards in four resident rooms out of eight resident rooms reviewed. As a result of this deficient practice, the facility put the safety and well-being of all the residents as well as the public at risk for electrical accident hazards, such as a fire. Findings Include: 1. During an observation of Resident (R) 93's room on 08/06/19 at 09:00 AM, an extension cord was noted to be plugged in to the electrical outlet. Connected to that extension cord was a power strip with the following three medical devices plugged in: two medical beds and a machine used for oxygen treatment. A second observation of R93's room on 08/07/19 at 10:00 AM, revealed the same findings as previously described on 08/06/19 at 09:00 AM. 2, During an observation of Resident (R) 46's room on 08/06/19 at 09:10 AM, an electrical	4 243	1. Maintenance Director removed all extension cords that were plugged into power strips for R93, R57, R9, and R46 and replaced with a longer surge protector. Maintenance Director was re-educated on proper usage of extension cords and power strips on 8/9/19. All residents have the potential to be affected. 2.Other rooms were inspected and are in compliance with the electrical devices' regulation. 3.Environmental Services Director provided education to Maintenance staff on 8/12/19 regarding guidelines on proper usage of electrical devices such as extension cords and power strips.	9/9/19

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4 243	Continued From page 15 power strip was noted to be plugged in to the electrical outlet. Connected to that power strip was the following two medical devices: two medical beds. A second observation of R46's room on 08/07/19 at 10:05 AM, revealed the same findings as previously described on 08/06/19 at 09:10 AM. 3. During an observation of Resident (R) 57's room on 08/06/19 at 09:15 AM, an extension cord was noted to be plugged in to the electrical outlet. Connected to that extension cord was a power strip with the following four devices plugged in: one medical bed, a machine used for oxygen treatment, TV, and fan. A second observation of R57's room on 08/07/19 at 10:10 AM, revealed the same findings as previously described on 08/06/19 at 09:15 AM. 4. During an observation of Resident (R) 9's room on 08/06/19 at 09:20 AM, an extension cord was noted to be plugged in to the electrical outlet. Connected to that extension cord was a power strip with the following four devices plugged in: one medical bed, a suction machine, TV, and fan. A second observation of R9's room on 08/07/19 at 10:15 AM, revealed the same findings as previously described on 08/06/19 at 09:20 AM. On 08/09/19 at 09:10, the Maintenance Director (Maint Dir) was queried about the above findings. Maint Dir acknowledged the above findings were a hazard and further stated that the building was old with only a few electrical outlets.	4 243	4. Environmental Services will conduct audits to validate that there are no extension cords plugged into power strips. Audits to include of 4 rooms x 4 weeks, then 4 residents per week x2 months. Environmental Services Director will report findings to QAPI committee meeting to evaluate the effectiveness of the plan based on findings and implement additional intervention to ensure continuous compliance. Compliance will be achieved by 9/9/19.	